

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40136

State File No.

FILED NOV 24 1953 88961

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 10793

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis, d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hospital.		e. STREET ADDRESS (If rural, give location) 19 3721 Westminster Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Gary b. (Middle) Don c. (Last) Akins		4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1953.	
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1953
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Sanford Akins		13b. MOTHER'S MAIDEN NAME Freda Grisson	14. NAME OF HUSBAND OR WIFE None.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Nil.		16. SOCIAL SECURITY NO. None.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sanford Akins 3721 Westminster.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature about 6 wks. with Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 7605	
22. I hereby certify that I attended the deceased from 11-10, 1953, to 11-13-53, that I last saw the deceased alive on 11-12-, 1953 and that death occurred at 4:00 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Oliver B. Kane M.D.		23b. ADDRESS 706 walter	23c. DATE SIGNED 11-13-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-13-53	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) Pocahontas, Arkansas.
DATE REC'D BY LOCAL REG. NOV 13 1953	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *George W. Wilkinson*.....

Licensed Embalmer No. 357

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.